TODAY'S TOPIC

Impact of Health Care Costs in Washington State

Dennis Braddock, Secretary
Washington State Department of Social and Health Services

SEPTEMBER 20, 2001

PART 1

The State That Took Charge

PART 1

A Bellwether State

- **Progressive – At the forefront of health care reform**

1988 DRG-based rates and contracts — Inpatient Hospital

1988 The Basic Health Plan

1989 Children covered to age 8 — 100 FPL

1990 Children 1 to 5 (Medicaid) — 133 FPL

1992 Children to age 19 (Medicaid) — 100 FPL

1994 Children to age 19 — 200 FPL Categorically Needy

1995 Child Dental Increase — From 45 to 65 percent paid

1999 Children's Health Insurance Program — 250 FPL

1987 Children covered to age 2 — Optional Categorically Needy

1988 Children covered to age 3 — Optional Categorically Needy

1989 Infants and pregnant women 185 FPL

1989 Catastrophic Coverage

1991 Children covered to age 18 — 100 FPL

AIDS — State Pays Medical Premiums for Certain Eligibles

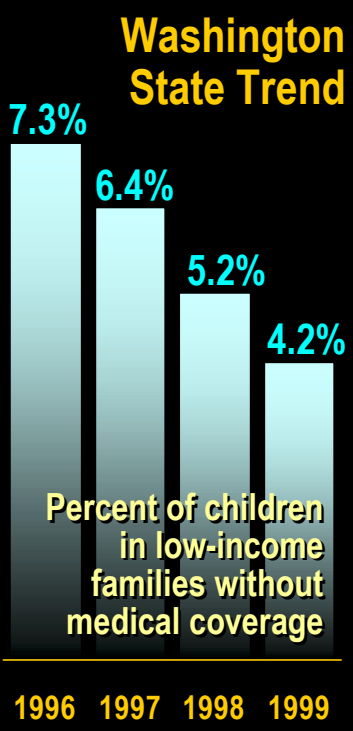
1993 "Healthy Options" for families — Mandatory Managed Care, King and Selected Other Counties

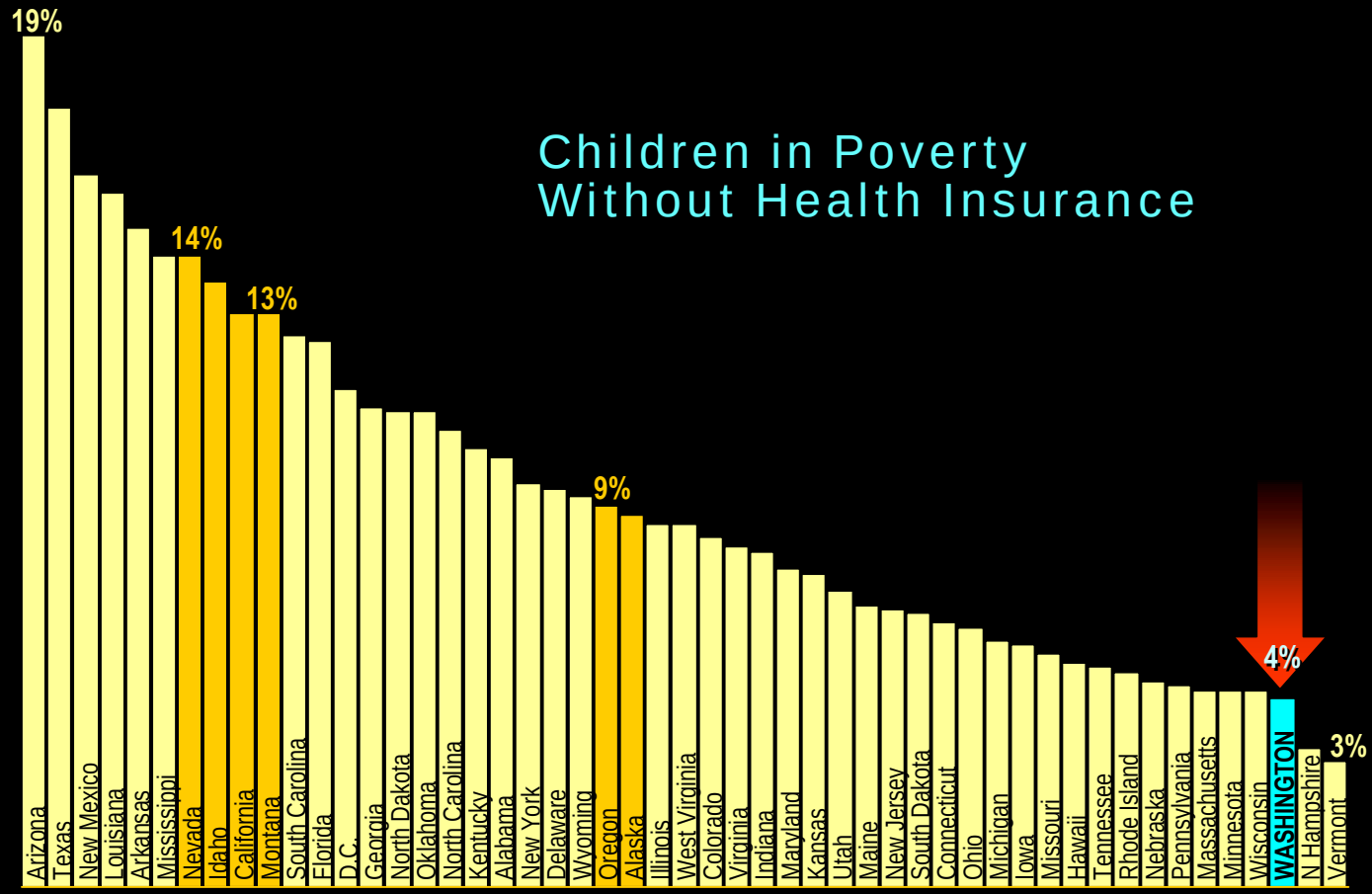
1997 "WorkFirst" Medical Insurance Upon Workforce (Re)Entry

PART 1

A Bellwether State

- **Progressive – At the forefront of health care reform**
- **All Embracing – One of the nation's best for child coverage**



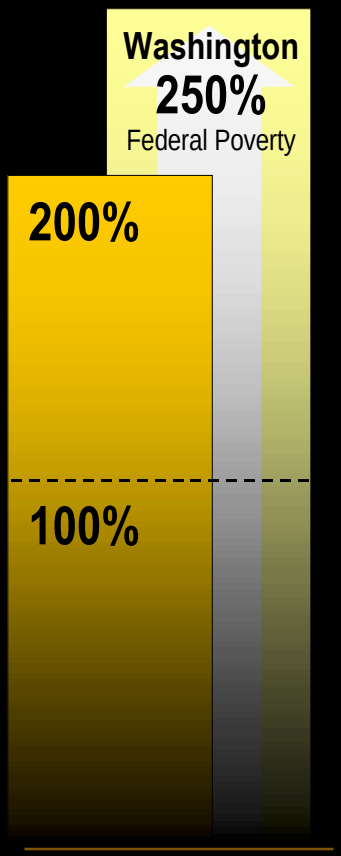


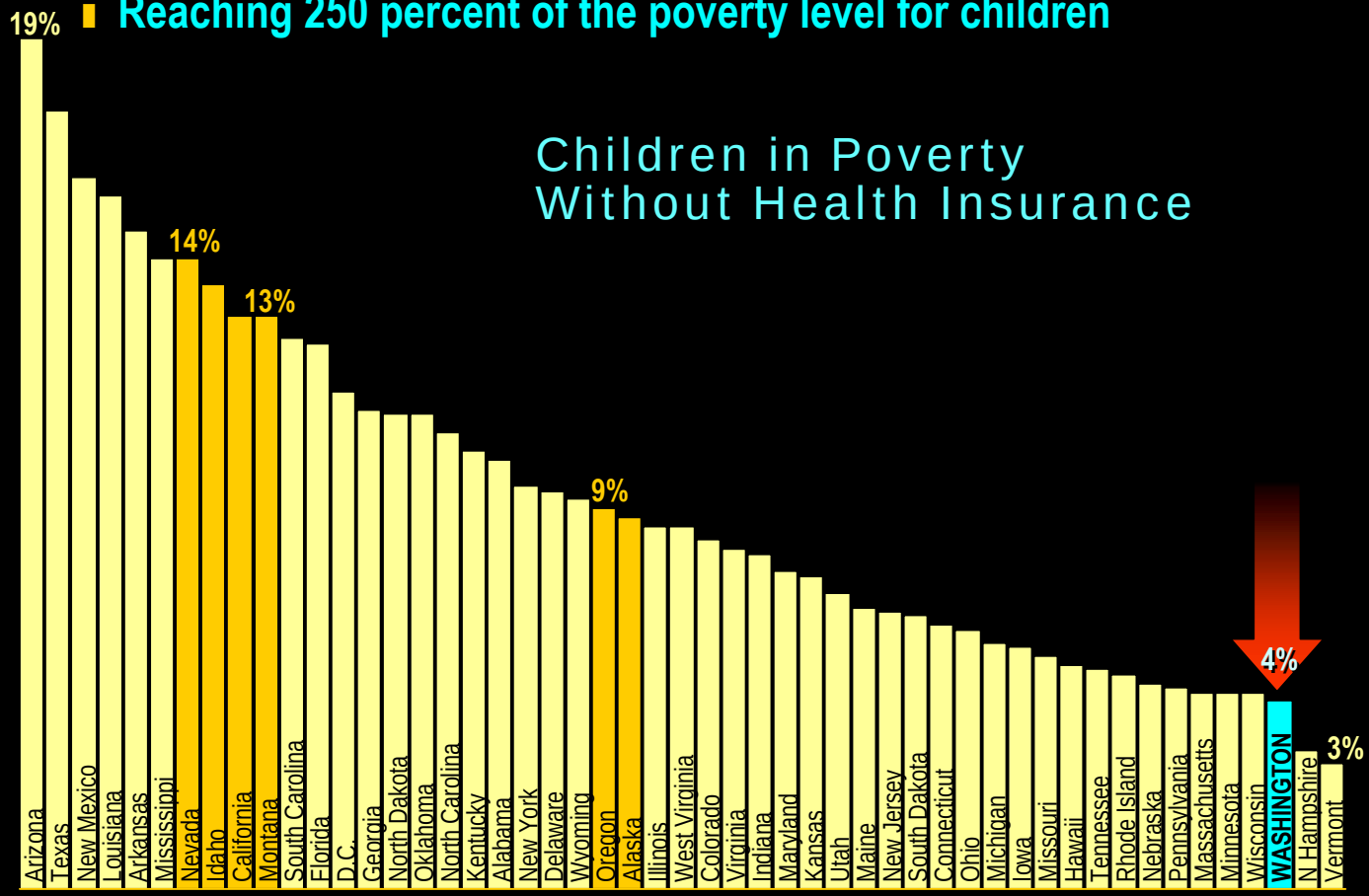
SOURCE: U.S. Census Bureau, Current Population Surveys, July 2001.
Charts show percent of uninsured children at or below 200 percent of federal poverty (three-year average, 1997-99)

PART 1

A Bellwether State

- **Progressive – At the forefront of health care reform**
- **All Embracing – One of the nation's best for child coverage**
  - **Reaching 250 percent of the poverty level for children**





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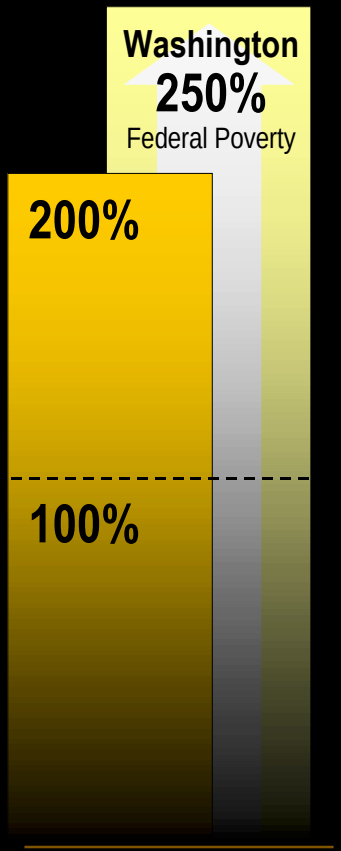
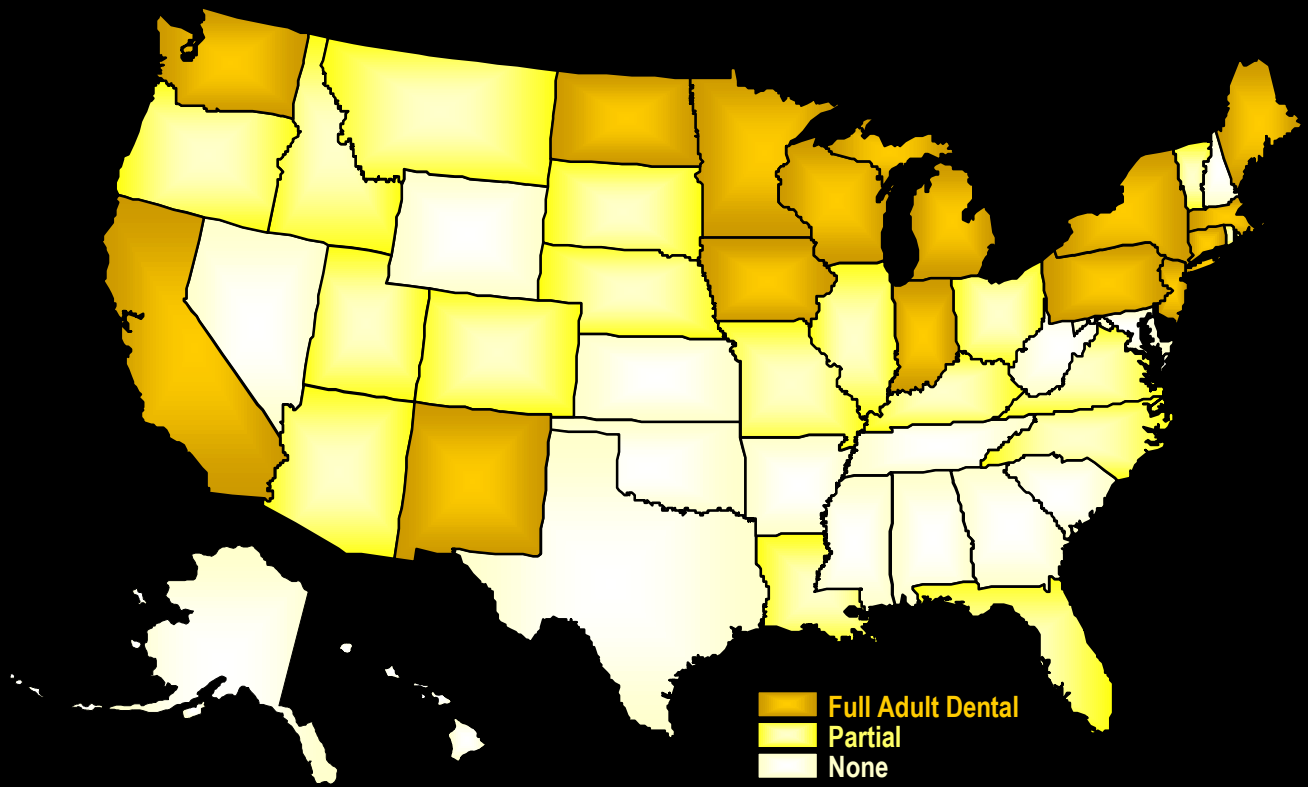
PART 1

A Bellwether State

- **Progressive** – At the forefront of health care reform
- **All Embracing** – One of the nation's best for child coverage
  - Reaching 250 percent of the poverty level for children
- **Comprehensive** – At the top end of the benefit scale
  - One of 15 states with full dental benefits for adults





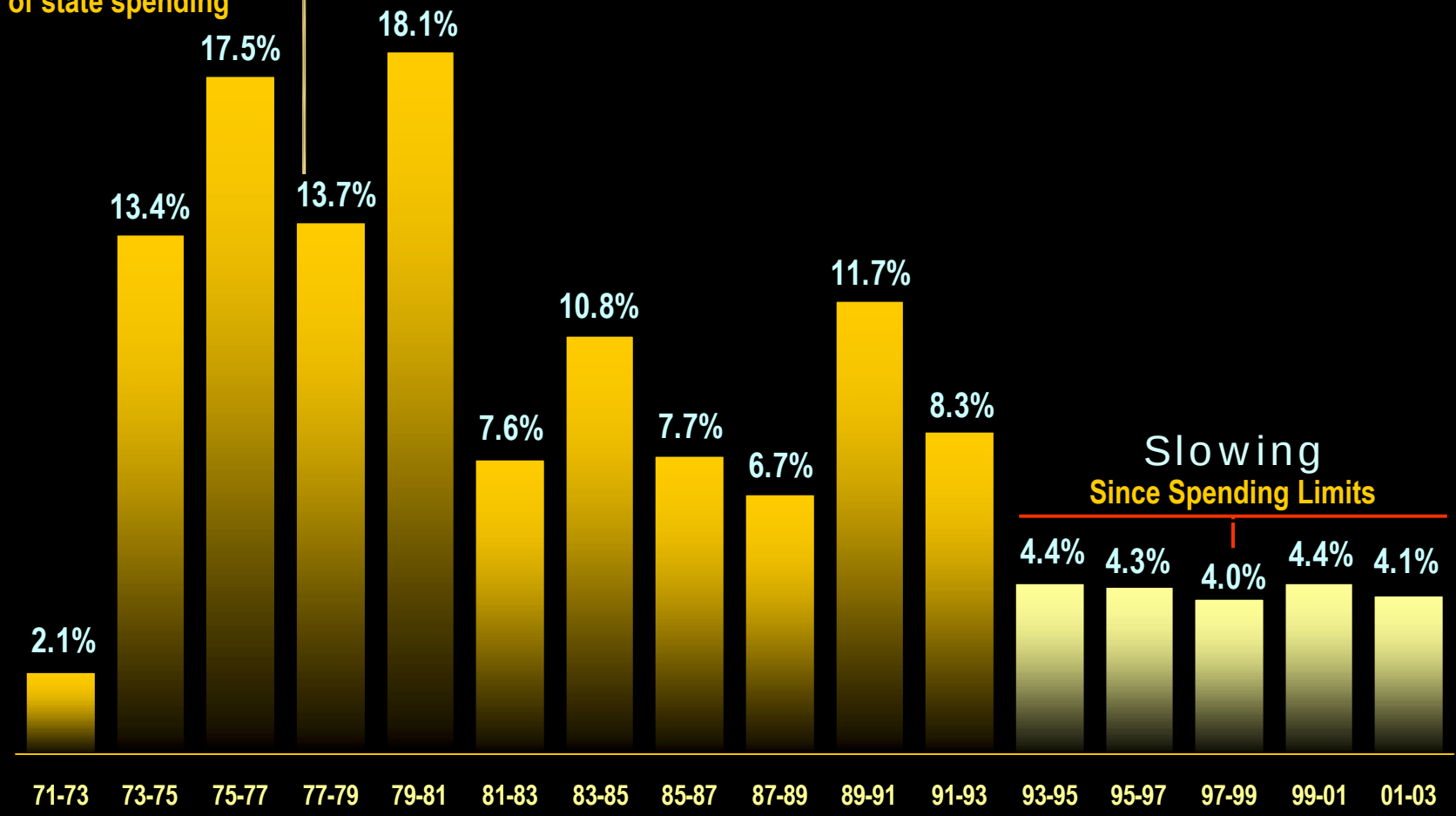
PART 2

Then What Happened?

PART 2

Facing Realities

- **Tighter Budgets**
  - **Faced with spending limits and tax initiatives**



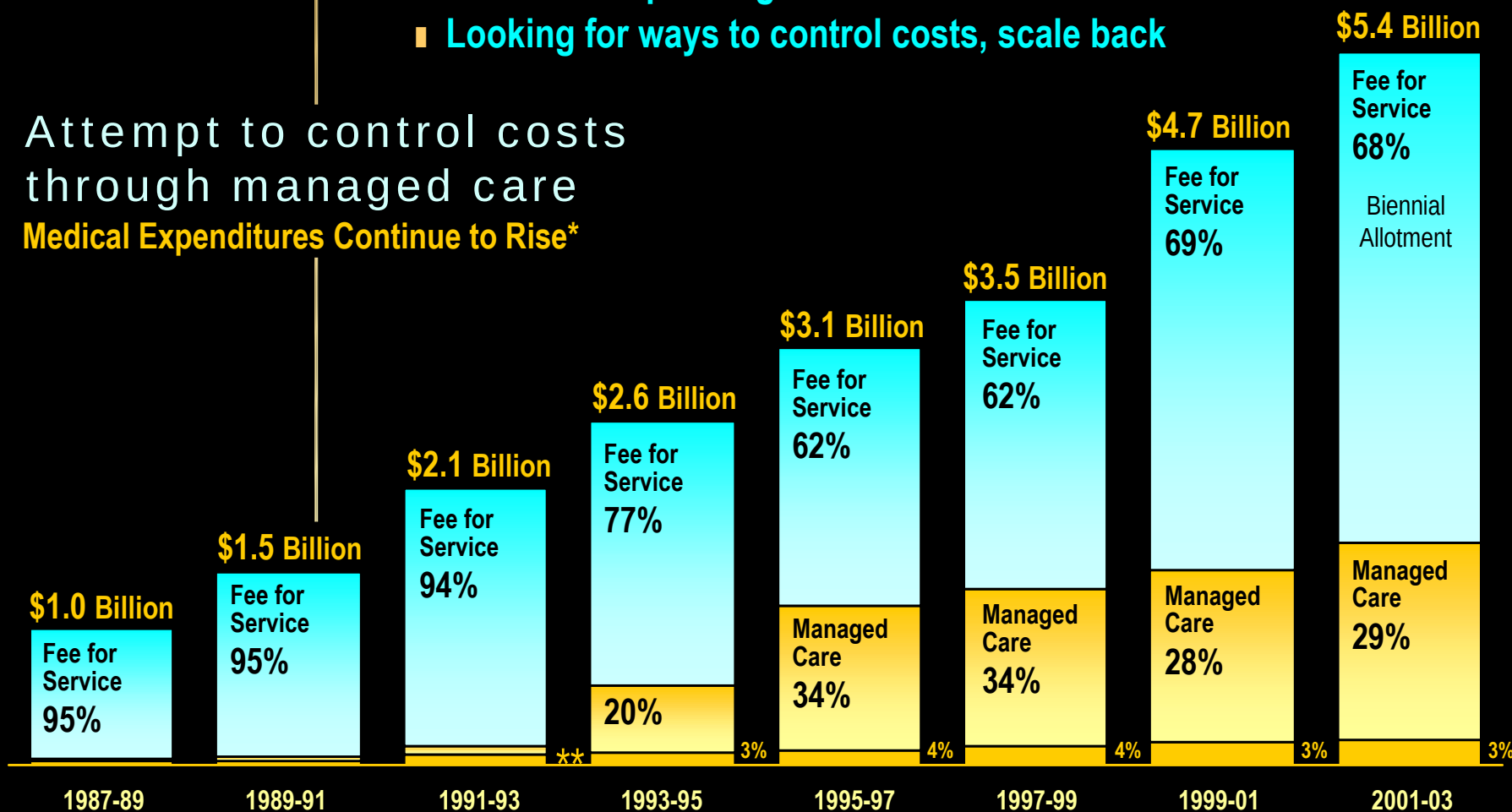
PART 2

Facing Realities

- **Tighter Budgets**
  - Faced with spending limits and tax initiatives
  - Looking for ways to control costs, scale back

Attempt to control costs through managed care

Medical Expenditures Continue to Rise*



* Chart reflects department total expenditure for services rendered or provided. Excluded from this figure are Upper Payment Limit transactions that

PART 2

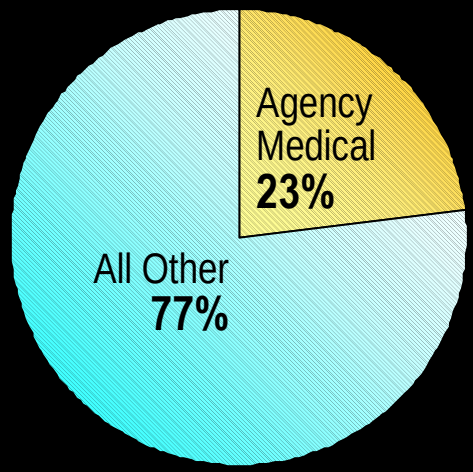
Facing Realities

- **Tighter Budgets**
  - Faced with spending limits and tax initiatives
  - Looking for ways to control costs, scale back
  - Consuming a growing part of the budget pie

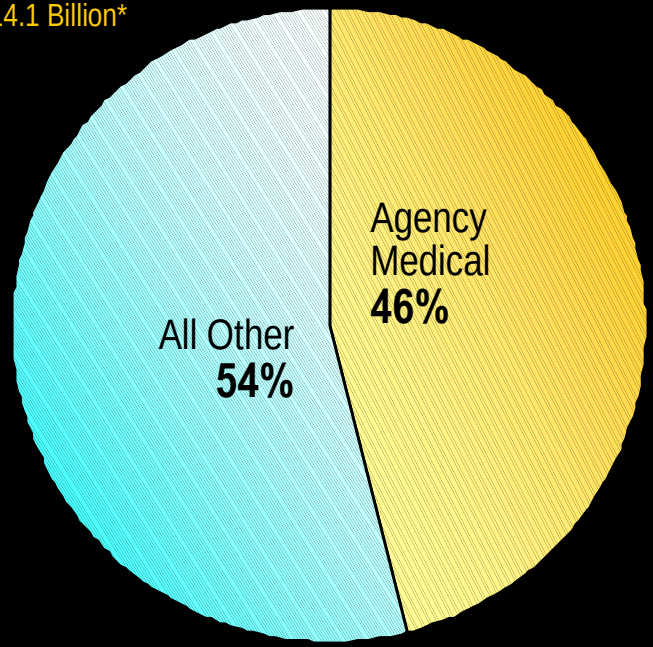
Medical Assistance

Consuming More and More of Our Agency's Budget

DSHS Budget
1987-89
$4.5 Billion



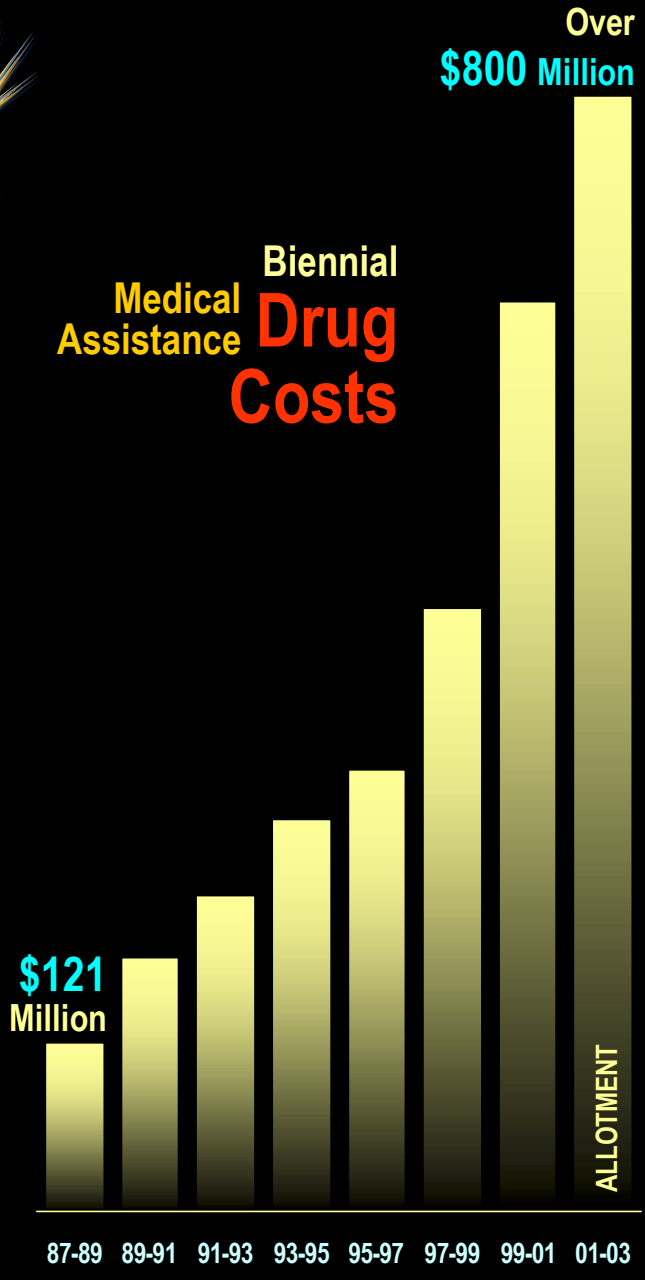
2001-03 Biennium
$14.1 Billion*

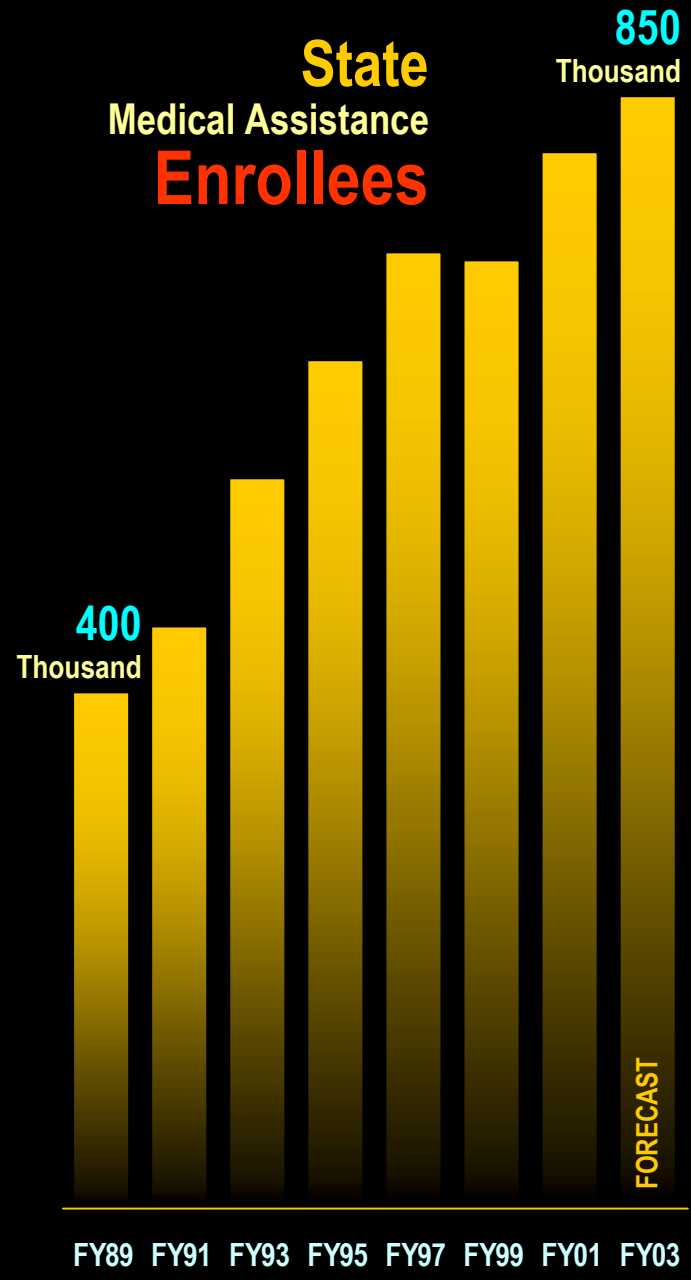


* Chart reflects department total expenditure for services rendered or provided. Excluded from this figure are Upper Payment Limit transactions that were made to Public Health Hospital Nursing Homes.

PART 2

Enrollment Drove Our Budget – Now It's Costs

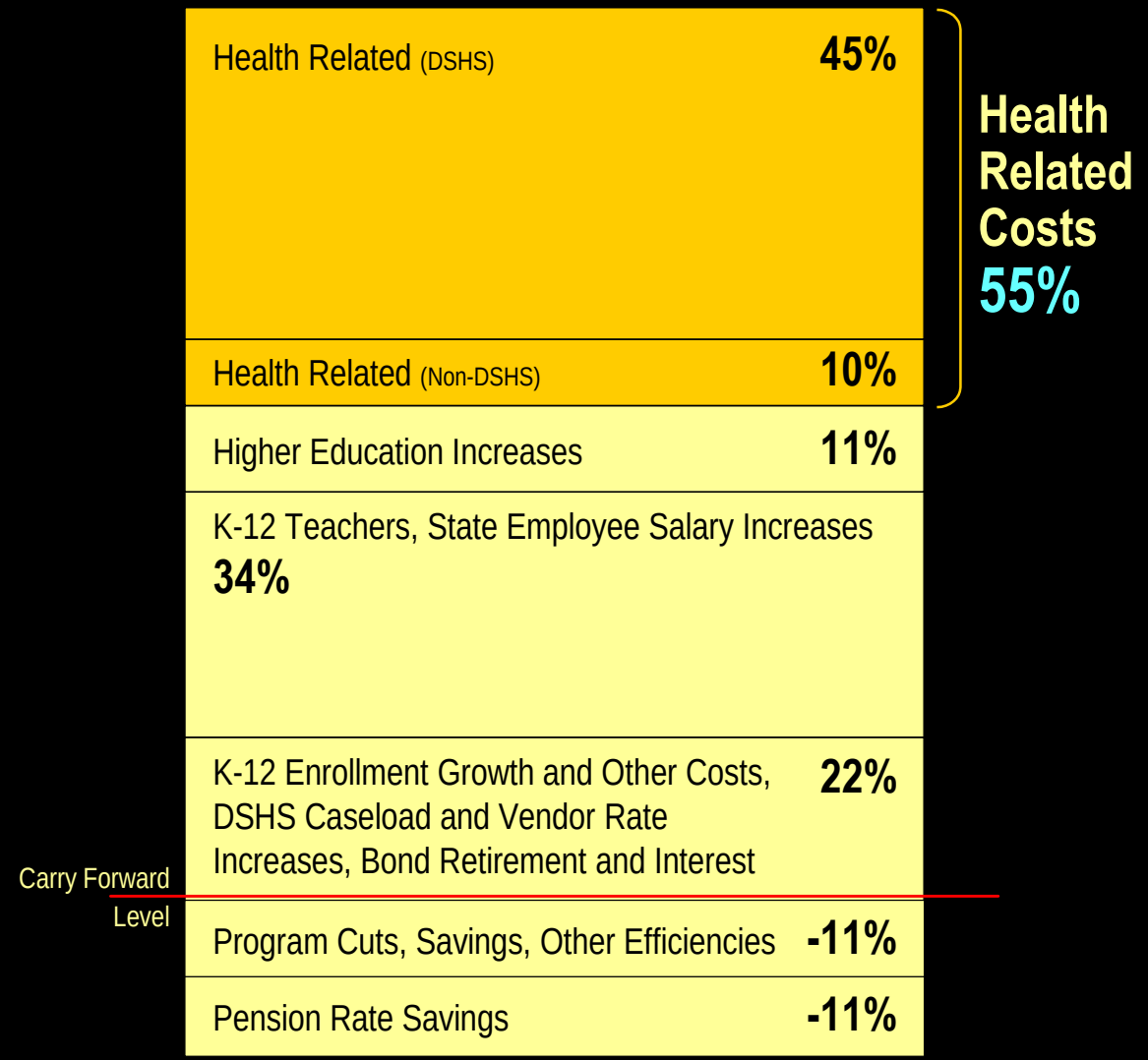




PART 2

2001-03 Budget Growth Factors

General Fund-State
Net Increase from
1999-01 to 2001-03
= **$1.7 Billion**



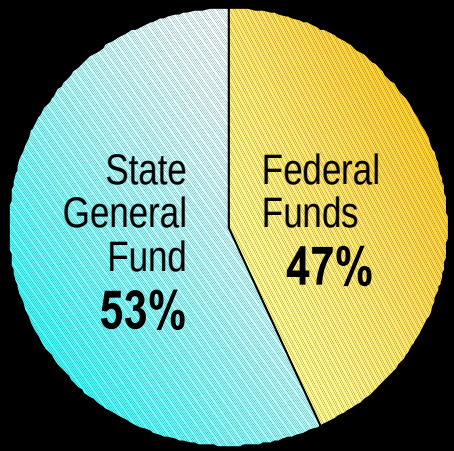
SOURCE: Office of Financial Management, August 2001.

PART 2

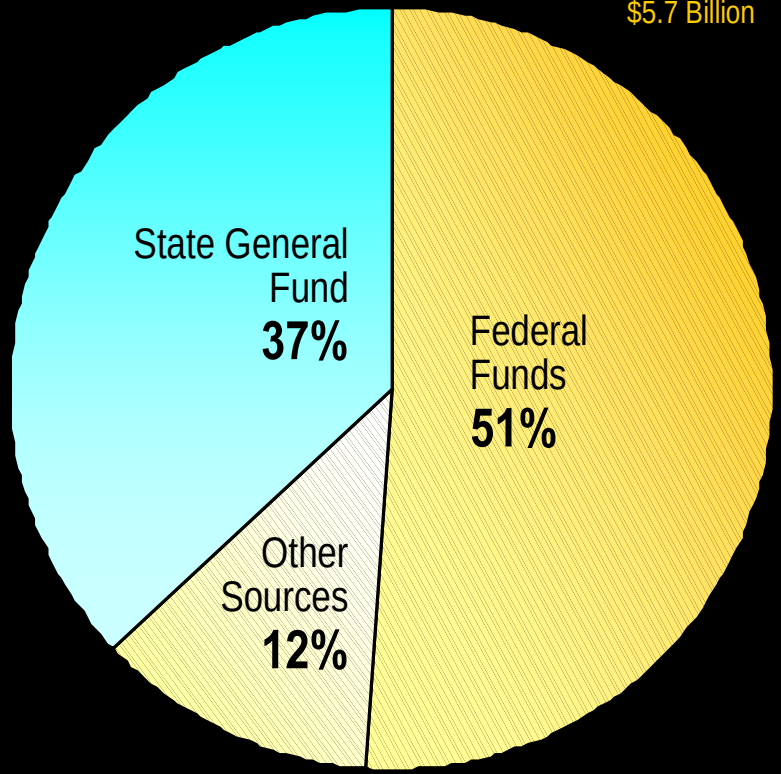
We're Turning to Other Sources of Funds

Federal Funds and Other State Accounts Help

Medical Assistance Payments 1987-89
$1.1 Billion



DSHS Medical Assistance Budget 2001-03
$5.7 Billion



PART 3

Controlling Costs

PART 3

A Big Picture Imperative

Know the Context

- The cost of providing health care to low income residents of the state *is not* the only component of the state budget
- Current demographics require minimal growth for the K-12 budget – *this will change* in the next two biennia, creating even harder budget choices for policy makers
- *Rate inadequacies* are making access more difficult
- Expenditure limit of *3 percent* per year versus *double digit* health care increases create their own pressure
- Other *social programs suffer from lack of resources* when health care costs grow unrestrained
  - Last welfare grant increase in this state was nine years ago
  - 25,000 individual providers care for the elderly, disabled, infirm in clients' homes for an average wage of $7.10/hour

PART 3

Examine All Options

Significant Cost Reductions Require Very Difficult Policy Decisions

- **Cover fewer people – eliminate entire groups from eligibility**
  - **EXAMPLES:**
  - Children in families with income above 100 percent of the Federal Poverty Level (FPL)
  - Individuals with income above 100 percent Federal Poverty with significant (expensive) medical conditions
- **Reduce the level of coverage – eliminate optional services**
  - Prescription drugs
  - Dental services
  - Vision care
  - Hearing care
  - Interpreter services
  - Medical equipment and supplies
  - Mental health services
  - Personal care
  - Substance abuse services
- **Pay less to providers**
  - Physicians
  - Hospitals
  - Therapists
  - Pharmacists
  - Managed care plans

PART 3

Control What You Can

Marginal Cost Control is Possible – We Will Pursue it for Fee For Service Clients

- **Aggressively pursue Third Party Liability and Coordination of Benefit recoveries**
- **Expand:**
  - **Hospital audits**
  - **Prior approval**
  - **Case supervision**
  - **Medical provider audits**
- **Implement**
  - **New payment rates to replace acquisition cost pricing**
  - **Prescription drug therapeutic consultation**
  - **Cost-sharing programs**
  - **Coordinated purchasing plan for prescription drugs with other state agencies**
- **Improve care coordination and prevention**

PART 3

Strengthen the State's Program

Manage the Business

- **Improve targeted reimbursement rate**
  - Improve rates that inhibit access
  - Improve rates that promote effective practices
- **Strengthen administrative functions**
  - Add key staff and invest in their success
  - Apply sound business practices to state program management
  - Invest in tools to manage well, like new uniform reporting standards (HIPAA) and medical information improvements (MMIS)
- **Push for program and policy flexibility**
  - Medicaid reform

PART 3

Medicaid Reform

Take Charge!

- Ensure the most vulnerable continued to have access to medical care
- Avoid "all-or-nothing choices" when costs exceed available funds
- Design flexible programs so . . .
  - . . . ***providers*** *can help control costs through the choices they make*
    - . . . ***consumers*** *can help control costs through the choices they make*
      - . . . ***policy makers*** *can help control costs and maximize access through the choices they make*
- Optimize federal resources to support coverage for low-income persons
- A waiver is required only for portions of this agenda

PART 3

Implement Reforms

Medicaid and SCHIP Reform Waiver Components

- **Provide policy makers with options over the life of the waiver**
  - Options would only be implemented to help sustain coverage for low-income people, and would require legislative approval
- **Waiver would provide flexibility to:**
  - Adopt reasonable co-payments to promote appropriate use of services
  - Adopt reasonable premiums for Medicaid optional programs, while continuing to emphasize primary and preventive care
  - Adopt different benefit designs for Medicaid optional programs, while continuing to emphasize primary and preventive care
  - Use waiting lists for enrollment into Medicaid optional and SCHIP programs when expenditures exceed appropriated funds
- **Waiver would seek approval for Washington to use unspent SCHIP allotment funds to:**
  - Cover parents of Medicaid or SCHIP children through the state's Basic Health program